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ABSTRACT

This study was designed to examine two contrasting types of parent groups in terms of their differential effects on parents and their disabled infants. The first type of parent support group was focused upon the psychological adaptation of mothers to their disabled child. It was hypothesized that the parent-centered group would directly affect the family by helping the mother cope with stress and in some cases depression, improving parental attitudes toward the child, and demonstrating emotional support from the group leaders and other parents. The second type of parent group was child-centered. This model was educational rather than therapeutic, focusing upon the transfer of information about child development and the impact of children's handicaps upon development, with an emphasis on teaching parents how to meet their child's special needs. Parents of 43 infants were randomly assigned to either parent-centered or child-centered groups for participation in the 10-month intervention program. Results indicated that neither type of parent group had the specific impact the investigators envisaged. The parent-centered group did not reduce stress or depression, lead to more positive attitudes about the child with handicaps, or result in perspectives of greater support from others. The child-centered group did not produce increases in knowledge about child development nor did it increase the child's developmental rate. Topics of discussion by mothers in the two types of parent support groups did not differ, even though the group leader directed the discussion to a greater extent in the child-centered educational groups. (JDD)

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A Comparison of Alternative Parent Group Formats in Early Intervention

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A Comparison of Alternative Parent Group Formats in Early Intervention

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The impact upon parents of an infant born with disabilities can be differential, depending upon the nature of the family's resources and personal abilities to cope. Specific personality characteristics of the mother, father, siblings, and extended family can determine the nature of the response to the infant with handicaps. The accommodations made by the family system can create an ecology which exacerbates or ameliorates the child's developmental problems (Sameroff & Fiese, 1990). This transactional perspective has led early interventionists to extend their efforts from direct attempts to ameliorate the child's disabilities to include also efforts to support families both psychologically and practically in their adaptation to the handicapped child (Dunst, Trivette, & Deal, 1988). Parent support groups are commonly used in center-based early intervention programs to address parental needs and provide information and support to families (Hanson & Lynch, 1989). However, very little data has been forthcoming regarding models of parent support or their impact upon parents and children with handicaps.

This study was designed to examine, experimentally, two contrasting types of parent groups in terms of their differential effects on parents and their handicapped infants. The first type of parent support group was focused upon the psychological adaptation of mothers to their handicapped child. A group therapy model articulated by Yalom (1975) guided the parent-centered group process. Yalom suggests that there are eleven primary categories of "curative factors" that can result in therapeutic change during group therapy. It was hypothesized that the parent-centered group would directly effect the family by: helping the mother cope with stress and in some cases depression associated with the birth of a child with handicaps,

with handicaps, improving parental attitudes toward the child, and demonstrating emotional support from the group leaders and other parents.

The second type of parent group was child-centered. This model was educational rather than therapeutic, focussing upon the transfer of information rather than applying a group process to prevent psychological pathology. In the child-centered groups, information was provided about the process of child development and the impact of children's handicaps upon development, with an emphasis on teaching parents how to meet their child's special needs. Educational topics were presented and parents were videotaped with their children for feedback and guidance within the group setting.

Procedures

This research was conducted at the University of Illinois Institute for the Study of Developmental Disabilities' Early Childhood Research and Intervention Program (ECRIP). The infant and caregiver attended the ECRIP for one two-hour session weekly. During the first hour, the caregivers and infants participated in group activities which were designed to facilitate infant development and address specific developmental problems. Groups were staffed by an interdisciplinary team made up of a combination of the following possible members, depending on the specific needs of a group: special educator, speech pathologist, physical therapist, occupational therapist, developmental psychologist, paraprofessional child development specialists, and master and doctoral level students. Groups consist of 6 to 10 caregiver-infant dyads and 4 to 8 staff members. During the second hour the parents adjourned to the parent room to participate in the parent group with group leaders (social worker, psychologist or nurse) while the infants received individualized intervention from the early intervention staff in the classroom. Parents were randomly assigned to either parent-centered or child-centered groups. Each parent group leader was assigned to conduct one parent-centered and one child-centered group to reduce differences associated with group leaders.

Subjects

Forty three famlies and their infants participated in the 10 month intervention program and parent-group study. All infants were assessed initially and at the end of the program using the Bayley Scales of Infant Development and the Uzgiris-Hunt Ordinal Scales of Psychological Development, scored to obtain age equivalents. In addition, mothers completed the following parent questionnaires: Beck Depression Scale, Rutter Malaise Scale, Questionnaire on Resources and Stress, Attitudes Toward Child Scale, Knowledge of Infant Development, and a rating of their resources in partner, family, friends, and professionals.

The average chronological age (CA) of infants (corrected for prematurity) was 12 months (S.D. =9 mos.) and average mental age (MA) was 6 months (S.D. =6 mos.) at the beginning of the program. There were no differences between groups of children assigned to parent group type with regard to CA, MA (obtained through either the Bayley or Uzgiris-Hunt Scales), or Bayley MDI. The two groups of mothers did not differ at the outset of the program in terms of their ratings of family resources, stress, anxiety, depression, knowledge of infant development, or attitudes toward their infant with handicaps.

Parent Support Group Interventions

Parent-Centered Counselling Model. The parents in the parent centered group determined the topics of discussion on any given day. Their only constraints were outlined in general instructions regarding the importance of not interrupting, not dominating the convesation and not being judgemental of the feelings expressed by others. The basic "curative factors" outlined by Yalom for a group process model are listed in Table 1. The group leader guided the group through these experiences, allowing the group to emphasize relative factors for its members. Since the group was implemented in an early intervention setting, a common focus of the group and leader was the shared experiences of parenting a handicapped child.

Child-Centered Educational Model. The group leader's role in these groups was that of parent educator and discussion leader. The specific 40 week format is summarized in Table 2. The first 12 weeks of the group focused on child development. The middle 13 weeks consisted of specific training modules designed to enhance parent-infant interaction. The parents received written handouts and the staff went over specific tasks and techniques during the group session. The parents then chose a specific task to focus on at home and would report back to the group the following week for assistance and feedback in the implementation of the chosen task or technique. For example, for module 5.3 (positioning), the staff and group members would assist a parent in determining an appropriate supported position for presenting tasks to the infant. The parents would review videotapes of their interactions with thir child to determine if they might better position the child to facilitate his performance in that context. Then parents would select more appropriate positioning. try them at home and report back to the group the following week regarding their success with new positioning techniques. The last phase of group sessions was devoted to improving the parent/professional partnership in early intervention. Parents were given information and discussion was facilitated about: the various roles of professionals, parental rights, what to expect in school staffings, how to represent their child's characteristics/needs to professionals, etc. It was hypothesized that the child-centered group would directly effect the child by increasing the parent's knowledge of child development and through application of specific techniques addressing individual child needs.

Assessment of Treatment Veridicality

A real time coding procedure was designed to determine if, in fact, the two interventions differed as intended. Each parent group was videotaped and six 10 minute segments of tape were selected randomly from the 40 sessions for each of the 10 groups of parents. The first and last group sessions were omitted from the random selection process due to the nature of group initiation and termination sessions. The first 10 minute segment was also omitted from the random selection since that time was often spent making announcements,

getting coffee, and waiting for all parents to get to the parent room. A staff member, who was not involved in tape coding, copied the selected segments in a random order onto four video cassettes for coding. The coder was blind to the group assignment and was not familiar with the parents.

An Epson HX-20 laptop computer was used for real time coding. The coder watched the videotape with the Epson on her lap, deflecting keys to indicate the onset of a category and the identity of the speaker. Keys were set to record either duration of a speakership or frequency of a events, in this case the topic of conversation. If parent 2, for example, began talking, the coder would hit duration key 2 which would stay on and the computer would count the number of seconds that parent 2 remained the speaker. At the end of the stream of talk, the coder would hit key 2 again which would turn it off, stopping the count. The coder would immediately hit the event key which best described that particular stream of talk, for example, feelings about the infant with handicaps

Event information was collected on 7 parent topic categories, 6 staff topic categories, and 2 video categories (since videotapes were used in the groups for presentaion of information and actual videotapes of the parent and child interacting for group discussion). See Table 3 for specific categories and example statements. The parent topic categories were collapsed for analysis into two categories: feeling and family issues (codes Q, R, Y) versus treatment and child-centered issues (codes W, E, T). It was hypothesized that the parent-centered groups would more frequently discuss topics in the first category, while the child-centered groups would be dominated by topics in the latter.

Printouts were produced following each coding session regarding event codes and duration codes keyed-in, in order of occurrence, as well as a summary of frequency by code for event codes and percentage of total time for duration codes. Duration information was collected on four mutally exclusive codes: parent talk, staff talk, video on, and silence. Each parent and staff member had their own duration code key. This information was used to compare percentage of time spent talking by parents versus staff. A second coder was utilized

to determine interobserver agreement on 5% of the randomly selected videotape segments. The average percentage of agreement was 89.5%. It was hypothesized that parents would talk more in the parent-centered groups, while staff would talk more in the child-centered groups.Parent and Infant Outcomes by Grouptype

Analyses

Multivariate repeated measures ANOVAs were conducted by group, time of testing, and parent measures: Stress (Friedrich Factors 1 and 2); Attitudes Toward Child Scale (5 factors); Beck Depression Scale; Resources (spouse, friends, family, professionals, overall adequacy); and Knowledge of Infant Development; as well as actual infant development (Bayley MA, Uzgiris-Hunt age equivalents). Post hoc univariate ANOVAs were conducted to examine any differences involving the type of parent group.

RESULTS

Differences in Parent Support Group Processes

Data was analyzed using the BMDP Hotelling T-Square procedure and the expected significant differences between groups were found with parents talking more in the parent-centered groups and staff talking more in the child-centered groups ($P < .001$). Because of the small N and reluctance to increase Type 2 error, data were analyzed using the SPSS-X independent T-Test procedure. No significant differences were found between the two groups in the frequency of discussion of feelings and family support issues versus specific discussion of the child. Thus, although the structure of the conversations in terms of relative distribution of speakerships was supported the differences in content for the two types of parent support groups were not as we had expected.

Child Development outcome and Impact Upon Parents

No differences associated with type of parent support group were found in any of the measures of child development or the measures of parents adaptations to a handicapped child.

A significant grouptype by time of testing by measure effect was obtained for the multivariate analysis of family resources (Hotellings T =.39; F=3.70; df 4, 38; p<.05). The univariate analysis for measures averaged across various types of resources (spouse, family, friends, confidants, and overall rated adequacy) produced a significant three way interaction (F=5.22; df 4, 38; p,.001). Univariate analyses revealed the source of this effect to be a significant increase in the rated adequacy of resources for the child-centered group while there was a significant decrease for the parent-centered groups across testings. In contrast to our hypotheses, no differences were found between groups in measures of maternal stress, knowledge of infant development or actual development of the infant with handicaps.

DISCUSSION

Neither type of parent group had the specific impact the investigators envisaged. For example, the parent-centered group did not reduce stress, depression, or lead to more positive attitudes about the child with handicaps, or result in perspectives of greater support from others. The child-centered group did not produce increases in knowledge about child development as measured by questionnaire, nor did it increase the child's developmental rate. However, the exposure to more detailed knowledge about child development and ways in which maternal behavior could effect such development appears to have given mother's a sense that resources for assisting them were more adequate. Since both groups received recommendations from a transdisciplinary team, the abstraction of such knowledge in a parent support group seems to produce the more immediate revision in one's sense of adequacy of resources. However, mothers of infants with handicaps who have participated in the parent-centered counselling model may feel that their resources are diminished when the parent support group ends. Thus they rate their resources to be less adequate than they were when they began the parent support group.

The fact that topics of discussion by mothers in the two types of parent support group did not differ even though the group leader directed the discussion to a greater extent in the child-centered educational groups suggests that the needs shared by parents with handicapped

infants will somehow be expressed when such parents are brought together. Hence including parent support groups probably does provide a forum within which parents can witness and explore the adaptation of other parents to young children with disablities, regardless of the specific group agenda.

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COUNSELING GROUP RESOURCE
PRE/POST

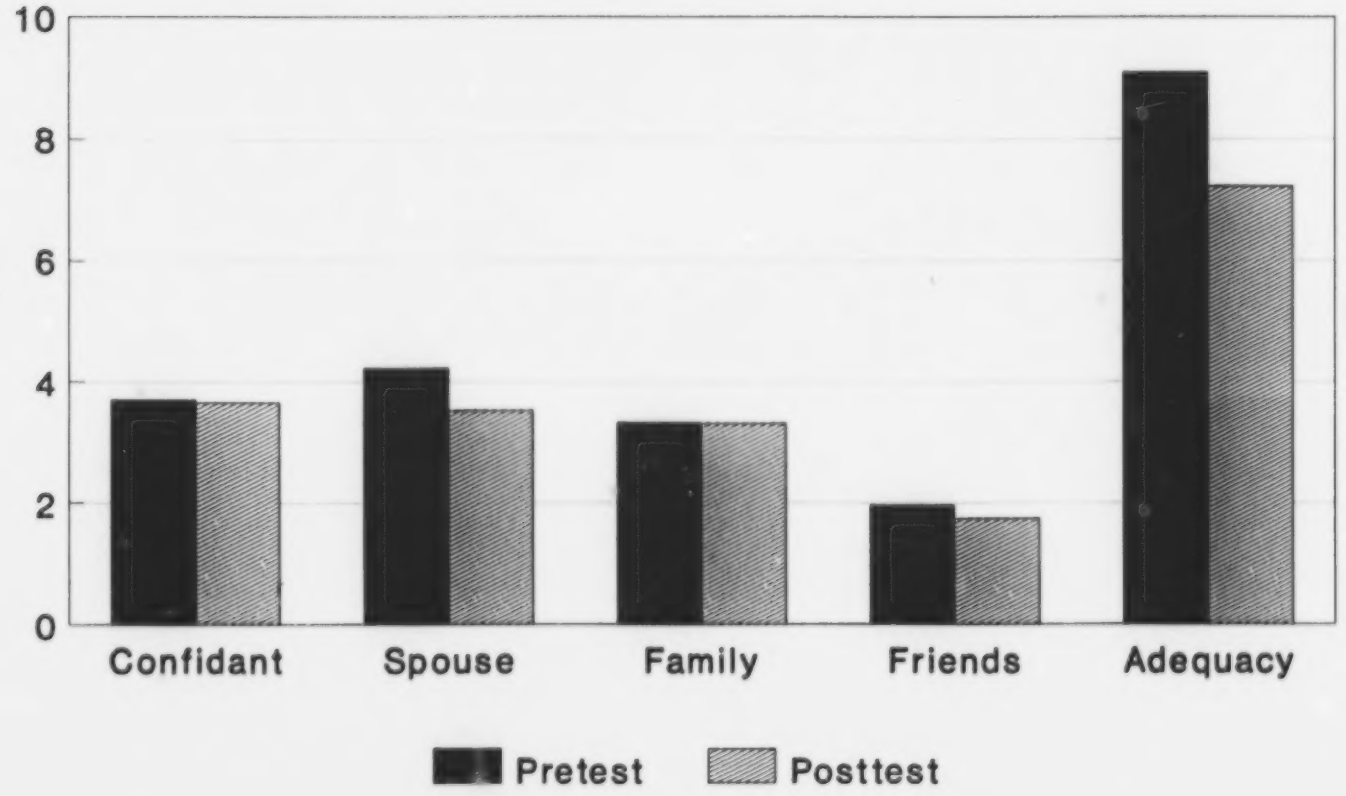


Table A

Yalom Curative Factors

1. Instillation of hope
2. Universality
3. Imparting of information
4. Altruism
5. The corrective recapitulation of the primary family group
6. Development of socializing techniques
7. Imitative behavior
8. Interpersonal learning
9. Group cohesiveness
10. Catharsis
11. Existential factors

Table B

Child-centered Parent Group Overview

1 INTRODUCTION AND ORIENTATION
2 OVERVIEW OF GROUP AND INFANT DEVELOPMENT TOPICS
3 PARENT PRE-PROGRAM QUESTIONNAIRES
4 CHILD DEVELOPMENT DURING THE FIRST THREE YEARS OF LIFE
5 Making sense of the booming buzzing confusion
6 Organizing the separate systems
7 Emotional life of the infant
8 Routines infants learn from - developing expectancies
9 Baby control and parent control
10 Motor control and motor development
11 Social development
12 Communication and language
13 Stages of development in the first three years
14 Review and discussion
15 TEACHING TECHNIQUES TO INCORPORATE INTO PARENT-INFANT INTERAC/TION (Introduction to Modules)
16 Review of goals which have been selected for each child
17 Mod 1: Task analysis-breaking things into smaller steps
18 Mod 2: Physical positioning & reduction of distraction
19 Mod 3: Attention gaining and waiting until the child is ready
20 Mod 4: Consistent labeling and use of words
21 Mod 5: Manipulation and modification of task
22 Mod 6: Limitation of choice
23 Mod 7: Physical prompting and fading of prompting
24 Mod 8: Rewarding
25 Mod 9: Indication and demonstration
26 Mod 10: Physical and verbal control of behavior
27 Mod 11: Verbal prompting and verbal feedback
28 PROFESSIONALS AND TEAMWORK - Introduction
29 Pediatricians
30 Early Childhood Educators/Special Educators
31 Physical Therapists
32 Occupational Therapists
33 Speech and Language Pathologists
34 Psychologists

35 Parents - making your case to a professional team
36 Parents - supporting parents
37 Summary and synthesis
38 Summary and synthesis
39 POST-PARENT QUESTIONNAIRES
40 CHILDREN'S GRADUATION AND PARTY

Table C

Epson Event Codes

Only items related in some way directly to the child's care, treatment, or handicap are to be included. Comments about shopping for a new dress for the baby or the neighbor's loud dog will be coded as OTHER. These codes refer to keys on a standard keyboard, programmed to record an event when the key is pressed.

PARENT EVENT CODES

Q ABOUT ME AND MY FEELINGS AND DEALINGS WITH MY HANDICAPPED CHILD.
(e.g., I feel that if I only worked harder with Joey, he'd get better. I feel guilty when I don't work with him.; I feel that I have total responsibility for Annie's care - my husband rarely helps me.)

W Treatment of my child (ECRIP and other EI programs, doctors, therapy, etc).
(e.g., The physical therapist at Michael Reese is so nice.; I like it when the teacher here tells me what Johnny did while I was in group.)

E About my child (excluding treatment - his development, special problems, handicap, personality, schedule, health, etc.)
(e.g., Johnny can't drink from a cup yet.; Brian is just like his father - stubborn.)

R Family feelings and dealings with my child ... father, siblings, extended family.
(e.g., My mother says she could get Angie to walk if I'd let her!; My husband wants another child, but is afraid, with all we've been through

with Amy.

T — About a general population (Down Syndrome Children, normal children, etc.)
(e.g., Do all Down Syndrome children have low tone?; Will my Kenny ever be able to run and play like normal kids?)

Y — Other's feelings and dealings with my child (non-treatment, non-family).
(e.g., The nurse came in and asked us if we'd considered adoption.; I wouldn't trust that day care center - the staff wouldn't look me in the eye and avoided looking at Andre.)

U — OTHER ... anything not related to the child and things about the child that are not relevant to the child's development or handicap.
(e.g., Jamie's hair is getting darker as she gets older.; My sister is trying to toilet train her 9 month old.)

VIDEO EVENT CODES

A — Educational presentation (e.g., NADS tape)

S — Review of tapes of children/parents in group (e.g., tapes of mothers teaching tasks to their child)

STAFF EVENT CODES

Z — Discussion of population or treatment issues in general.
(e.g., We do want all of you to work on the tasks, but don't let it get to be a burden. It's more important that you enjoy your child.; Sidelying is a good position for children with cerebral palsy.)

X — Discussion of treatment issues about a specific child/parent in the group.

(e.g., You may need to sit Vicky in her tumbleform chair for that task.; Try modeling feeding of Joey for your husband.)

C — Question ... Relevent question about parent. (e.g., Does it bother you to leave Leah to come in here for parent group?; Do you have enough support from your relatives?)

V — Question ... Relevant question about child. (e.g., How did Jay react to the new therapist?; Have you tried the rubber-tipped spoons?)

B — Question ... Relevent open question to the group. (e.g., Have all of you contacted NADS?; Did anyone else have a similar hospital experience?)

N — OTHER (e.g., My husband refuses to change diapers too.)